STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/15/11 Facility Number: 000459 Provider Number : 155567 AIM Number: 100289700 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, University Park Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 104 and had a census of	K0000	*This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	80 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/18/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 38 residents in the east hall. Findings include: Based on an observation with the Maintenance Director on 03/17/11 at 3:26 p.m., in the ceiling drywall above the drop down ceiling at the 300 short hall fire wall a twelve inch split at a	K0025	Damaged ceiling repaired by Maintenance on March 16, 2011 To ensure no other residents were affected, Maintenance inspected space above drop ceiling throughout the facility. No other damages noted. Maintenance shall monitor ceilings quarterly to ensure the deficient practice does not reoccur. Results of quarterly monitoring shall be forwarded to QA quarterly for 1 year to ensure compliance.	04/13/2011

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	drywall seam has dropped down one half inch from what appears to have been weight or pressure applied from above. Measurements were provided by the Maintenance Director at the time of observation. 3.1-19(b)			
K0029 SS=E	Based on observation and interview, the facility failed to ensure 1 of 1 roll down doors at an opening in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect any residents in the main hall dining room. Findings include: Based on observation with the Maintenance Director on 03/15/11 at 12:10 p.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore considered to be the	K0029	Fire curtain to be updated to allow closure with activation of fire alarm. No residents have the potential to be affected by deficient practice. Monitoring shall be added to monthly fire drill form. The rolling fire door in the pass through shall be updated by Advanced Systems Group with a Fire Fly to be activated by the fire alarm system on April 6, 2011. Maintenance to monitor proper activation monthly in conjunction with fire drills. Results to be reviewed by Executive Director monthly for 1 year.	04/13/2011

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	corridor wall. There was a pass through opening in the corridor wall between the dining room and the kitchen. The opening was protected with a rolling fire door with a fusible link. Based on interview with Maintenance Director at the time of observation, the rolling fire door does not close upon activation of the fire alarm. 3.1-19(b)			
K0046 SS=E	Based on observation and record review, the facility failed to ensure 2 of 2 emergency light fixtures of at least 1½ hour duration were tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual	K0046	No residents were affected by deficient practice due to ceiling lights being activated by generator power supply. Facility reviewed entire building to ensure no other batter operated lights were present. Due to generator activating sufficient lighting in building, indicated battery operated lights were removed on March 21, 2011. Due to removal of battery operated lights, monitoring not necessary to ensure compliance.	04/13/2011

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	inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any occupants in the Therapy room. Findings include: Based on an observation with the Maintenance Director on 03/15/11 at 2:10 p.m., there were two battery operated emergency lights in the Therapy room. Both lights were tested and failed to illuminate. During the record review process, the Maintenance Director was unable to provided written records of monthly checks or an annual test regarding the battery operated lights in the Therapy room. 3.1-19(b)			

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K0050 SS=F	Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Report" with the Maintenance Director on 03/15/11 at 11:45 a.m., there was no record of a first shift fire drill for the second quarter of 2010. Based on an interview with the Maintenance Director at the time of record review, two first shift drills were conducted in the first quarter by mistake during a transition period with a new computer program. 3.1-19(b) 3.1-51(c)	K0050	Copy of missing fire drill found post Life Safety Survey Exit. No residents affected. Executive Director to review upcoming fire drill schedule with Maintenance to ensure proper timing of fire drills. Copies of fire drills to be reviewed by Executive Director monthly for 1 year. Results to be monitored by QA quarterly on an ongoing basis.	04/13/2011

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K0056 SS=E	Based on observation and interview, the facility failed to ensure 4 rooms in 1 of 6 smoke compartments were equipped with one type of sprinkler head, i.e., quick response sprinklers or standard sprinklers. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect all residents in the Therapy room and any number of staff in the dry food storage room. Findings include: Based on observations with the Maintenance Director on 03/15/11 between 2:05 p.m. and 2:20 p.m. the Therapy room had a mixture of quick response sprinkler heads and what appeared to be standard response sprinkler heads. Based on an interview with the Maintenance Director at the time of observations, he could confirm the quick response sprinkler heads were rated at 155 degrees Farenheit but he was unable to find a rating for the remaining sprinkler heads therefore he could not confirm these sprinkler heads also	K0056	All sprinkler heads identified in the Therapy Room and the Dietary Department were replaced by Shambaugh and Son to match on March 29, 2011. All facility sprinkler heads were reviewed to ensure there were not a mixtures of sprinkler head types in any one smoke compartment Sprinkler heads will be reviewed quarterly with the contracted inspections to ensure there is not mixture of sprinkler head types. Results of this audit will be brought to QA quarterly for one year then annually thereafter to ensure compliance.	04/13/2011

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	had a rating of 155 degrees Farenheit. The same issue was found in the dry food storage room with a mixture of quick response sprinkler heads and possibly standard response sprinkler heads. 3.1-19(b)			
K0067 SS=E	Based on observation, record review and interview; the facility failed to ensure 2 of 2 dampers in the ventilation system were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect four of six smoke compartments. Findings include:	K0067	All identified dampers in facility will be inspected by contracted fire inspection company. Dampers to be inspected by Advanced Systems Group on March 30, 2011. Maintenance to add damper inspections to contracted fire inspections on a 4 year rotation. Damper inspection to be added to TELS(automatic notification system for maintenance department) on a 4 year reminder.	04/13/2011

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	Based on observations with the Maintenance Supervisor on 03/15/11 during a tour from 2:55 p.m. to 3:12 p.m., there were fire dampers in the attic ventilation system at the west hall fire wall near resident room 109 and at the 300 short hall fire wall. Based on an interview with the Maintenance Supervisor during the record review process at 12:35 p.m., the dampers have not been inspected during his employment at the facility and he has no documentation to show the inspections were done prior to his arrival at the facility. 3.1-19(b)			
K0147 SS=D	Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice	K0147	Extension cord removed from Housekeeping office. Housekeeping Supervisor reeducated on not using extension cords in the facility. Facility inspected for any additional extension cords in use. None found. Reeducation for all staff regarding the prohibition of extension cords in the facility on April 5, 2011. Maintenance to add extension cord observation to quarterly rounds. Results of review to be reported to QA quarterly for 12 months.	04/13/2011

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	could affect any staff member in the Housekeeping office and any resident in or near the Housekeeping office in the event of an emergency. Findings include: Based on an observation with the Maintenance Director on 03/15/11 an extension cord was plugged in and suppling power to the following pieces of equipment in the Housekeeping office: a computer, printer, drill charger, fan and an alarm clock. Based on an interview with the Maintenance Director at the time of observation, the facility does not allow extension cords and the Housekeeping Supervisor was told to immediately unplug and remove it. 3.1-19(b)			